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INSURED EMPLOYEE BENEFIT

PLAN REVIEW AND AUDIT

State of Montana

December 1982



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State of Montana

December 1982

STATE OF MONTANA

Office of the Legislative Auditor

STATE CAPITOL
HELENA, MONTANA 59620
406/449-3122



DEPUTY LEGISLATIVE AUDITORS

JAMES H. GILLET
FINANCIAL COMPLIANCE
AND CONTRACTED AUDITS

SCOTT A. SEACAT
PERFORMANCE/SUNSET AUDITS

STAFF LEGAL COUNSEL
JOHN W. NORTHEY

November 10, 1982

ROBERT R. RINGWOOD
LEGISLATIVE AUDITOR

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of selected aspects of the
Department of Administration State Employees Benefit Plans.

The audit was conducted by Peat, Marwick, Mitchell & Co., CPAs,
under a contract between the firm and our office. The comments and
recommendations contained in this report represent the views of the
firm and not necessarily the Legislative Auditor.

The agency's written response to the report are included in the
back of the audit report.

Respectfully submitted,

Robert R. Ringwood
Robert R. Ringwood
Legislative Auditor



Peat, Marwick, Mitchell & Co.

Certified Public Accountants

2000 Commerce Tower
P.O. Box 13127
Kansas City, Missouri 64199

December 3, 1982

Mr. James H. Gillett, C.P.A.
Deputy Legislative Auditor
State of Montana
State Capitol
Helena, Montana 59620

Dear Mr. Gillett:

We have completed our review and audit services for the State of Montana's insured employee benefit plans and are pleased to present our report. It is organized as follows:

- . Introduction,
- . Results: Claim Payment Accuracy,
- . Results: Claim Payment Turnaround Time,
- . Results: State Administration,
- . Results: Management Reports,
- . Conclusions and Recommendations: Claim Payments,
- . Conclusions and Recommendations: State Administration; and
- . Conclusions and Recommendations: Management Reports.

A brief summary of each of these sections is included in this letter.

SUMMARY OF RESULTS

Our findings with regard to claim payments, State administration of the benefit plans, and management reports for the benefits are presented below.

Claim Payment Accuracy

Blue Cross of Montana (BC) implemented a new computerized claim payment system as of August 1, 1981. Our audit of claim payment accuracy covered the period August 1, 1981 through July 31, 1982. Based on our audit, we observed that:

- Health care claim payment errors occurred in 2.5 percent of the claims in our audit sample, a reduction in frequency from 6 percent in our audit last year.
- Health claim net underpayments were .02 percent of the dollar payments in our audit sample, compared to a net overpayment of 1.3 percent in our audit last year.
- Dental claim payment errors occurred in 9.5 percent of the claims in our audit sample.
- Dental claim net overpayments were 5.28 percent of the dollar payments in our audit sample.
- Twelve of the nineteen dental payment errors discovered involved (a) Extractions, (b) Crowns, or (c) Fluoride treatments for adults. (Corrective action in these three areas is discussed in more detail in the report.) Exclusive of these errors, the observed frequency of error was 3.5 percent and the net underpayment was .38 percent.

Prior to August 1, 1981, dental claims were processed by Aetna Life Insurance Company. Error frequency and magnitude work was not performed for the 1980 - 1981 dental plan year at the request of the Department of Administration. As a result, comparison to dental error rates in the prior year could not be made.

Claim Turnaround Time

In prior years, BC made benefit payments on a daily basis. Health and dental claim payments are now being made through a State checking account. Payments are now made to hospitals biweekly and to patients and other providers once per week. Based on our analysis of data regarding claim payment turnaround time, we concluded that:

- Claim payment turnaround time during the 1981-1982 plan year was slower than during the prior year.
- Turnaround time delays during the first six months, were caused, (in part) by difficulties in the computerized system.
- Turnaround time delays during the second 6 months were caused (in part) by the State's decision to issue claim checks on a weekly and biweekly basis.
- Ninety-one percent of the claims reviewed for turnaround time that were incurred and paid during the second six months of the 1981-1982 plan year were paid within a reasonable period of time or had documentation of appropriate reasons for delay.

State Administration

Our services regarding State administration of the benefit program involved a review of recommendations made in our January, 1982 report and a review and audit of the eligibility and premium collection process for the health and dental program. Our findings are as follows:

- . Many of the recommendations contained in our January, 1982 report have been implemented and have produced improved administration.
- . Eligibility and premium reporting compares favorably to last year.
- . Incomplete enrollment and premium collection transactions still occur, resulting in additional effort on the part of D of A personnel and delays in claim payments by BC.
- . Eligible employees are not always enrolled promptly and eligibility status changes are not always identified on a timely basis by agency payroll clerks.

Management Reports

The timeliness and accuracy of information presented in management reports is vital to the proper management of a large health and dental benefit program. The State has begun a wellness program and other educational programs designed to reduce claim expenses. Appropriate management reports are needed to identify areas of containable costs and to monitor the effectiveness of cost containment efforts. Our findings regarding Management reports are that BC:

- . Has agreed to provide management reports (e.g. claim listings and utilization reports).
- . Provides a monthly report listing premium income, number of members and paid claims and recently provided an annual utilization report for the 1981-1982 Plan year.
- . Has offered to provide additional management reports based on the State's administrative needs.

Conclusions and

Recommendations: Claim Payments

Based on our analysis of audit and review information, we conclude the following regarding the claim payment function:

- . Error frequency and magnitude data developed during our audit of health care claims is favorably low compared to last year's audit results and favorably low compared to results of similar audits performed by PMM&Co.
- . Error frequency and magnitude data developed during our audit of dental care claims are high compared to results of similar audits performed by PMM&Co.
- . Claim payment turnaround time improved during the second six months of the 1981-1982 Plan year compared to the first six months.

Claim payment accuracy and turnaround time are a function of (a) the quality of the claim information provided to the processor, (b) the procedures and systems used to process claims, and (c) the processors' familiarity with Plan provisions. We make the following recommendations regarding the claim payments function:

- . BC should increase processor training to reduce the frequency of incorrect payments and payment for noncovered services based on Plan provisions.
- . BC should consider computer program modifications to avoid processor errors in co-insurance payments.
- . BC and D of A should develop a participant and provider education program designed to improve the quantity and quality of information received on the initial claim submission to improve claim payment turnaround time.

The frequency and magnitude of health care plan errors observed are very low compared to results of similar audits. The results of our audit this year indicate that BC has been successful in reducing the frequency and magnitude of errors in this plan. The first two recommendations above are directed primarily to the dental care plan.

Conclusions and
Recommendations: State Administration

Based on our review of State administration of the Plan and our audit of premium and eligibility transactions we conclude the following:

- . Recommendations in our January, 1982 report that have been acted on, have improved the State's administration of the Plan.
- . Errors continue to be made and delays in Agency administration continue to occur in the areas of determination of employee eligibility, changes in status, and self-payment of premium.
- . BC's use of the State generated computer tape of eligible employees has improved the process of identifying and correcting differences in coverage and premium collection.

The premium collection and eligibility processes are vital to the effective administration of the Plan. Incomplete and erroneous eligibility data may: (a) delay the effective date of insurance coverage, (b) delay claim payment by BC, and (c) result in employee dissatisfaction with the Plan. We recommend the following regarding State administration:

- . A uniform enrollment and payroll deduction authorization form should be developed to provide for enrollment and/or coverage changes in life, health and dental coverage and to authorize appropriate payroll deductions so as to eliminate the need for multiple forms for various coverages.
- . An updated Administration Manual for payroll clerks should be prepared to assist payroll clerks in performing their administrative duties.

- . D of A should periodically audit the eligibility of employees whose employment status has changed (e.g. from part time temporary to full time) to verify that eligible employees are given an opportunity to enroll in the Plan.

Conclusion and

Recommendations: Management Reports

Based on our review of management reports provided to the State and the use of such information, we conclude that:

- . BC is providing basic premium, participant and claim statistics on a monthly basis.
- . BC has provided claim utilization information for the 1981-1982 Plan year.
- . The State has not completed the development of a cost containment and claim monitoring program. As a result, the State and BC have not yet discussed information needs and report capabilities.

Our recommendations regarding management reports are as follows:

- . D of A personnel and BC representatives should meet to clearly identify their needs for management information and agree on a timetable for receiving these reports.
- . Reports should include analysis of claims by procedure, length of stay, sex-relation code, place of treatment. Additional information should include:
 - frequency of admission, and
 - trend data regarding utilization, total and average claim payments.

STATE AND BC RESPONSES

Drafts of this report were provided to the Department of Administration and Blue Cross for their comments. Copies of their written comments are attached as Exhibits A and B to this report. The Blue Cross comments are very brief and a response, by PMM&Co., is not appropriate. Our response to the Department of Administration comments is presented below. The headings correspond to those in the Department of Administration letter.

III. RESULTS: CLAIM PAYMENTS

TURNAROUND TIME

We cannot disagree with the observation that claim payment delays occurred because of the payment cycle. The analysis of turnaround time was, in part, intended to identify reasons for delays. The 27 claims in our sample that were processed within 14 days but paid after the 18 or 20 day period were not paid within an acceptable turnaround time. However, the delay was not as a result of the claims adjudication system. The delay is the result of the payment cycle.

IV. RESULTS: STATE ADMINISTRATION PRIOR YEAR'S RECOMMENDATIONS

TERMINATION INFORMATION

In our report last year, we suggested the State develop a packet of information to be provided to terminating employees regarding the termination of their employee benefits and their right to convert life and health coverage to individual policies. The purposes of this suggestion were to:

- . Provide such employees with information and instructions, and
- . Reduce the possibility that a terminated employee would feel he had not been given adequate notice of his rights.

BC does provide conversion information. However, they cannot do so until they are notified of the employee's termination by the State. Often this notice has been one or more months following actual termination of employment.

If each agency provides terminating employees with conversion information, the intent of our recommendation is satisfied. The intent of suggesting a packet of information was to assure availability of proper data for terminating employees regarding their conversion rights.

Employee Benefits Bureau
Administration Manual

Our draft report stated that an administration manual had not been prepared. Our review of the Bureau's procedures this year did not identify the use of a manual. We now understand that the manual was prepared, but is not used to administer the Plan.

The use of the manual will help in identifying procedural improvements and can be of value in keeping the manual current.

* * * * *

We appreciate the opportunity to be of service to the State of Montana in this most important program.

Yours truly,

Pat Marwick, Mitchell & Co

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I-INTRODUCTION

The State of Montana (State) provides health care and dental care insurance as part of an overall employee benefit program for State employees including elected officials, certain retired employees and their dependents. The State pays the premium for active employees and a portion of the premium for dependent coverage. The State does not contribute toward the premium for employees on leave of absence. Approximately 10,000 employees are participating in the insurance programs. About 50 percent of the employees have elected to insure their dependents under the health care and dental care insurance.

Blue Cross of Montana (BC) provides the health care and dental care insurance for all employees and dependents. The contract between the State and BC was renewed as of August 1, 1981. As of February 1, 1982 the funding method was changed from the experience rated insured method to the minimum premium insured method.

PURPOSE OF SERVICE

Section 2-18-816, MCA (Montana State Law) requires the State Legislative Auditor or an independent certified public accountant to perform an annual audit of the State employee group benefit plans. Peat, Marwick, Mitchell & Co. (PMM&Co.) was engaged to perform audit and review services for the BC plan and the State's internal plan administration pursuant to an Audit Contract dated September 17, 1982. The purpose of the services was to comply with Section 2-18-816, MCA.

SCOPE OF SERVICE

The scope of our service was stated in our proposal letter dated August 18, 1982 to Mr. Rod Sundsted, Chief, Labor Relations and Employee Benefit Bureau. Our services included:

- . A review and audit of BC payment accuracy and turnaround time for health care and dental care claim payments during the 1981-1982 plan year,
- . A review and audit of State administration of the Plan including eligibility determination, and premium payment, and
- . A review of Management Reports prepared by BC.

II - RESULTS: CLAIM PAYMENT ACCURACY

Our claim payment accuracy review for the health care and dental care plans for the year ended July 31, 1982 involved a random selection of health care and dental care claims paid during the 1981-1982 plan year. The audit sample was selected on a random basis so as to permit comparison of results with similar audits, the results of last year's health care plan audit and future audits of the State's health care and dental care plan.

AUDIT SAMPLE CHARACTERISTICS

We selected a sample of 200 health care and 200 dental care claims. All claims selected were both incurred and paid during the 1981-1982 plan year. The total payments in the sample were: \$20,744.57 health care payments and \$9,818.50 dental care payments.

ERROR FREQUENCY - HEALTH CARE

We identified five claims, of the 200 in our health care sample with errors resulting in incorrect payments. This represents a 2.5 percent error frequency and compares favorably with the 6 percent error frequency identified in our audit of health care claims for the 1980-1981 plan year. The audit sample for the 1979-1980 plan year was selected judgmentally and results should not be compared to results from a random sample audit. The frequency and magnitude of the errors are summarized in Table II-1 below.

TABLE II - 1
HEALTH CARE PLAN
CLAIM PAYMENT ERRORS

<u>Type</u>	<u>Frequency</u>	<u>Magnitude</u>	
		<u>Overpaid</u>	<u>Underpaid</u>
Accident Claim Paid As Sickness Claim	2	\$	\$ 128.66
Payment For Non-Covered Service or Supply	2	112.76	
Interpretation of Billed Services	<u>1</u>	<u>11.20</u>	_____
Totals	5	\$ <u>123.96</u>	\$ <u>128.66</u>

ERROR MAGNITUDE - HEALTH CARE

Three of the five claims with payment errors involved overpayment errors. These overpayments totaled \$123.96 (.60 percent of the claim payments in the sample). The two claims with underpayments totaled \$128.66 (.62 percent of

the claim payments in the sample). The underpayments, net of overpayments, were \$4.70 or .02 percent of the \$20,744.57 claim payments in the sample. The net underpayment magnitude of .02 percent of claim payments compares favorably with the net overpayment magnitude of 1.3 percent of claim payments in our audit sample for the 1980-1981 plan year.

ERROR FREQUENCY - DENTAL CARE

We identified 19 claims, of the 200 in our sample of dental care claims, with errors resulting in incorrect payments. This represents a 9.5 percent error frequency in the sample. We have not made a comparison to dental claim error frequency in prior years. At the request of the State, the audit sample for the 1979-1980 plan year was selected judgmentally and no dental claim audit work was performed for the 1980-1981 plan year.

The frequency and magnitude of the errors are summarized by type in Table II-2 below.

TABLE II - 2
DENTAL CARE PLAN
CLAIM PAYMENT ERRORS

<u>Type</u>	<u>Frequency</u>	<u>Magnitude</u>	
		<u>Overpaid</u>	<u>Underpaid</u>
Tooth Extraction(s)	5	\$ 115.26	\$
Crown(s)	3	413.14	
Flouride Treatment for Adults	4	34.98	
Others Overpaid	2	1.75	
Others Underpaid	5		<u>46.70</u>
Total	<u>19</u>	\$ <u>565.13</u>	\$ <u>46.70</u>

ERROR MAGNITUDE - DENTAL CARE

Fourteen of the 19 claims with payment errors involved overpayment errors. These overpayments totaled \$565.13 (5.76 percent of the claim payments in the sample). The five claims with underpayments totaled \$46.70 (.48 percent of the claim payments in the sample). The overpayments, net of underpayments, were \$518.43 or 5.28 percent of the \$9,818.50 claim payments in the sample.

COMPARISON OF ERROR RATES

Based on error information provided to us by several insurance company and Blue Cross/Blue Shield claim departments, error frequencies generally

range from 4 percent to 6 percent and net payment errors generally range from 1/2 percent to 3/4 percent. The results of PMM&Co. audits conducted under conditions similar to this year's audit produce error rates somewhat higher than those reported by claim departments. The results of our work generally indicate an error frequency range from 5 percent to 7 percent and net payment errors generally range from .6 percent to 1.0 percent among claim departments for whom we have performed audits.

The frequency of error (2.5 percent) and the net underpayment magnitude (.02 percent) for the health care plan are both below the frequency and magnitude rates:

- . Identified in our audit last year,
- . Reported by other claim departments, and
- . Identified in similar PMM&Co. audits.

The error frequency (9.5 percent) and magnitude (5.28 percent) are both in excess of the frequency and magnitude rates reported by other claim departments and identified in similar PMM&Co. audits.

III - RESULTS: CLAIM PAYMENT TURNAROUND TIME

Claim turnaround time was measured from the date the claim documents were first received by BC to the date the benefit check was mailed. While other measurement periods are used for turnaround time, PMM&Co. uses the "receipt to mail" period as it more closely approximates the period experienced by plan participants than any other turnaround time measure commonly used.

Our analysis of claim turnaround time covered 195 health care and 199 dental care claims from our sample. Six of the 400 claims in the sample contained illegible receipt dates that could not be verified accurately from other sources.

MEASUREMENT METHOD

Claim checks are now issued to hospitals and to patients and other providers once each week rather than every day as in prior years. In prior years, our measurement of acceptable turnaround time was based on a "receipt to mail" period of 14 calendar days. Due to the change in payment frequency under the plan, the measurement period was extended to 18 days for dental claims and 20 days for medical claims to compensate for delays caused by the infrequent payment schedule.

TURNAROUND TIME RESULTS

Average turnaround time (by month the claim was received) for both health and dental claims is presented in Table IV-1 below.

TABLE IV - 1
HEALTH AND DENTAL CLAIMS
AVERAGE TURNAROUND TIME

<u>Month Received</u>	<u>Average Turnaround Time</u>	
	<u>Health Claims</u>	<u>Dental Claims</u>
August, 1982	34.8 Days	52.2 Days
September	35.9	38.1
October	39.6	34.4
November	35.7	34.2
December	47.1	25.6
January, 1982	36.7	27.0
February	23.3	17.5
March	16.9	13.8
April	21.5	19.3
May	24.6	20.5
June	22.1	20.4
July	21.0	13.8

Turnaround time was very slow during the first six months of the plan year. The major reason for this delay appears to be computer related difficulties in the claim adjudication process. Turnaround time improved during the month of February, 1982 and generally was progressively better each succeeding month.

Claims in our sample with turnaround times in excess of 18 days for dental claims and 20 days for medical claims, which were received during the last six months of the plan year, were reviewed to identify reasons for delays.

Of the 204 claims in our sample which were received and paid during the last six months of the plan year, 71 (35 percent) were processed in a time period in excess of the 18 or 20 day acceptable period. Our analysis of the reasons for delay is presented in Table III-2 below.

TABLE III-2
CLAIM TURNAROUND TIME
ANALYSIS OF DELAY

<u>Type</u>	<u>Number of Claims</u>
Claims Requiring Appropriately Longer Adjudication Time	25
Claims Processed Within 14 Days, But Payment Cycle Produced Delay	27
Claims Without Identifiably Appropriate Reason For Delay	19

Of the 204 claims, in our sample, received and paid during the last six months of the plan year, 185 or 91 percent were processed within an appropriate turnaround time or included proper documentation of a delay which was not a fault of the claims adjudication system. The remaining 19 claims did not contain documentation to support the period of delay in the turnaround time.

APPROPRIATE
CLAIM DELAYS

If proper claim adjudication is to be performed, not all claims will be processed within a two or three week period. In determining appropriate delay periods, we evaluated the documentation for claims. Reasons for appropriate delay included:

- Requests for basic information such as: diagnosis, treatment performed, and charges by procedure.
- Verification of coverage (premium delayed due to self-pay, change in coverage status, or partial monthly premium.
- Request for accident reports or Coordination of Benefits information from other insurance including Medicare.

IV - RESULTS: STATE ADMINISTRATION

The results of our review and audit regarding the State administration of the benefit program are presented below.

PRIOR YEAR'S
RECOMMENDATIONS

Each of the recommendations regarding State administration made in our January, 1982 report are presented below together with the action taken by the Department of Administration (D of A) and an observation regarding the effectiveness of the action taken.

Revise Payroll
Clerk Manual

We recommended the Payroll Clerk Manual be revised to more clearly describe the administration process.

- . Action Taken: The manual was revised.
- . Effectiveness: Improvement has been noted by D of A personnel. Manual may need additional revision.

Expand Payroll Clerk
Training Program

We recommended Employee Benefit Bureau (EBB) personnel expand the Payroll Clerk training program to include additional training for clerks experiencing difficulties with plan administration.

- . Action Taken: Additional training has been provided on an "as needed" basis.
- . Effectiveness: Sufficient results are not available to be sure, but EBB personnel believe the additional training has been effective.

Request Assistance from
Other Agency Personnel

We recommended D of A request the assistance of Agency personnel to insure the proper flow of information to Payroll Clerks for proper administration.

- . Action Taken: None. Improvements from other action tend to have reduced the need for this recommendation.

Modifications to
Payroll System

We recommended that one time and regular payroll deduction requests be submitted and processed at the same time to reduce errors and delays. We also

recommended the Payroll System be modified so as to automatically increase life insurance premiums resulting from age or salary changes.

- . Action Taken: The payroll deduction form submission recommendation was implemented. No action has been taken regarding automatic premium increases.
- . Effectiveness: Errors resulting from a lack of proper payroll deduction forms have been reduced. No accurate records of the volume of such errors is maintained by EBB. Ms. Loughrie stated that the volume of such errors has been significantly reduced. Life Insurance premium changes must still be made manually, but improved processing of edit listings of such errors has reduced life insurance premium payment deficiencies. Currently, the reduced time required to prepare the life insurance premium statement may have eliminated the need to make premium increases automatically.

D of A Should Review Self-Pay and Coverage Termination Options

We recommended that these present provisions be reviewed and consideration be given to improved provisions designed to reduce delays and administrative complexity.

- . Action Taken: The provisions have been reviewed. No action to change the provisions or procedures has yet been taken.

Waiver of Premium - Life Insurance

We recommended data for employees on self-pay status be reviewed to determine eligibility for a waiver of premium claim under the life insurance plan.

- . Action Taken: Data for employees requesting self-pay status for medical reasons now is reviewed to determine eligibility for waiver of premium.
- . Effectiveness: The recommendation has been effective in identifying eligible employees.

Premium Refund Activity

We recommended photocopies of handwritten worksheets be sent to Central Services and BC in support of premium refund requests rather than preparing typewritten requests. We further recommended refund checks be delivered to Payroll Clerks or mailed to employees rather than to deliver them to EBB.

- . Action Taken: The recommendations have been implemented.
- . Effectiveness: The recommendations have resulted in a substantial reduction in work load, permitting EBB personnel to devote time to

other administrative needs. No accurate record of time spent performing this function is available. Reductions in the number of payroll deduction errors have also contributed to the time reduction in this area.

Collection of Self-Pay Premium

We recommended the use of a CRT to assist in the processing of self-pay premiums to eliminate the monthly processing of repetitive transactions.

- . Action Taken: Ms. Loughrie, the EBB staff person responsible for this task is currently using a CRT for this procedure.
- . Effectiveness: This recommendation has produced a reduction of three to four hours per month in the time required to process self-pay premiums.

Interdepartment Transfers

We recommended EBB improve the description of procedures regarding the transfer of benefit plan information for employees transferring to another department.

- . Action Taken: Revised instructions were added to the new Manual.
- . Effectiveness: The recommendation has resulted in improved compliance with transfer procedures. During the 1981-1982 plan year, only one employee's coverage was interrupted as a result of a transfer.

Termination Information

We recommended the preparation of an information packet providing information and instructions for continuation and conversion of insurance benefits for employees who terminate employment.

- . Action Taken: No action has been taken regarding this recommendation.

Leave of Absence

We recommended Payroll Clerks send self-pay instructions to employees when the clerks became aware of employees who are not in pay status. The purpose of this recommendation is to reduce the number of retroactive self-pay requests and possible coverage termination resulting from a failure to submit self-pay premiums on a timely basis.

- . Action Taken: No action taken. EBB is currently reviewing the situation.

Due Date of Self-Pay Premiums
and Requests for Refund

We recommended that self-pay premiums and requests for premium refunds (for terminated employees electing not to extend their coverage) be submitted no later than the first of the month.

- . Action Taken: Self-pay premiums are still received on the ninth of the month, however, refund requests must now be received prior to the first of the month.
- . Effectiveness: The revised refund request procedure has been of help to the EBB staff and has reduced the volume of requested refunds.

Eligibility
Verification

We recommended Payroll Clerks review pre-payroll listings on a monthly basis to verify eligibility of employees for plan participation.

- . Action Taken: The Payroll Clerks have been advised to perform this review.
- . Effectiveness: EBB reports the recommendation has been effective. Our review of eligibility disclosed two employees who may be eligible but were not properly enrolled.

EBB Administration Manual

We recommended a manual describing the EBB administrative procedures be prepared to aid in providing consistent administration.

- . Action Taken: The EBB administration manual has been written.

ELIGIBILITY
AND PREMIUM

The results of our review of the process of determining eligibility and the collection of premium and our audit of eligibility/premium transactions are presented in this section.

Claimant
Eligibility

During the claim adjudication process, BC verifies the eligibility of each patient based on premium and eligibility information provided by the employer (State).

Our audit of 400 claims paid during the 1981 - 1982 plan year included a verification of the eligibility of each claimant based on BC records. All 400 claimants in our sample were covered by the State's health care and dental care plans based on eligibility records at BC. We provided D of A information

regarding date of service and employee Social Security numbers for 200 of the selected claims. Mr. Sundsted reported that EBB verified that all 200 employees were covered by the plan when their claims were incurred.

BC will not process a claim for an individual unless premium has been paid for the month in which the claim was incurred. We did observe situations where claim payments were delayed until verification of premium payments were obtained.

D of A Procedures

D of A administrative procedures require two transactions to properly add or change the coverage status of a participant in the plan. Each is briefly described on the following page:

- . Coverage. The Payroll Clerk must properly complete a form to enroll, add, or remove dependents from the plan. The form is then sent to D of A and BC picks up the forms for processing.
- . Premium. The Payroll Clerk must properly complete and send to Central Payroll (part of D of A) a notice of payroll deduction to start, increase, decrease, or stop payroll deductions.

It should be noted that no procedure exists for the Payroll Clerk to notify BC of an employee's termination of coverage. Only through failure to receive premium does BC know that coverage has been terminated.

Premium and coverage reports are provided to BC each month. D of A does not have an administrative procedure to verify that all coverage and premium transactions are correct. BC reviews the premium and coverage information and notifies D of A of any identified discrepancies.

Audit Results: Eligibility and Premium Collection

Our initial work program was to include an audit of 100 eligibility and premium collection transactions. At the request of Mr. Rod Sundsted, Chief, Labor Relations and Employee Benefits Bureau, our work program was modified to include a review of previously identified eligibility and premium collection errors.

We judgmentally selected 62 eligibility and premium discrepancies identified by BC and, also judgmentally selected 57 employees listed on State records as not participating in the health care and dental care plan. The results of our audit and review of these items are presented in Tables IV-1 and IV-2.

TABLE IV-1
ANALYSIS OF ELIGIBILITY AND
PREMIUM COLLECTION ERRORS

<u>Type</u>	<u>Number</u>
Age Change - Medicare Eligible	11
Joint Core Eligibility and Premium	6
Effective Date Delay due to Health Statement	7
Payroll Deduction Notice In Error (not otherwise listed)	4
Incorrect Payroll Deduction based on Enrollment Form	14
No Error	9
Error Source Could Not Be Identified	<u>11</u>
Total	<u>62</u>

Of the 62 transactions audited, 53 involved uncorrected errors. Nine transactions were corrected in a subsequent period and are reported as "No Error" in Table IV-1.

Errors involving Joint Core Eligibility and Payroll Deductions appear generally to have resulted from Payroll Clerk failures to match the employee deduction amounts to the requested coverage.

The Age Change - Medicare Eligible errors occurred because the State premium collection system can not automatically adjust premiums as a result of an age change. BC has agreed to advise the State of such age changes in the future.

The probable source of the remaining 11 transactions could not be identified.

Our audit of eligibility for benefits of the 57 selected employees produced the following results:

- . Forty-six employees eligibility and enrollment appear to be correct.
- . Five employees had declined coverage, but had not completed a waiver card.
- . Two employees would not complete their enrollment cards.
- . Two employees appear to be eligible, but have not been advised of their eligibility.

V - RESULTS: MANAGEMENT REPORTS

Our services regarding management reports for the health care and dental care plan involved a review of the reports presently received by the State from BC, the State's use of present reports, and the State's need for additional information. The review of present reports included analysis of (a) the usefulness and timeliness of data and (b) the accuracy of data. The results of this review are presented below.

DATA PRESENTED

BC prepares a Cost and Benefit Distribution report, a claim payment Breakdown Report and a Claim Lag report on a monthly basis. These reports are sent to Mr. Byers of William Mercer, Inc. (Consultant to the Plan) with copies to D of A. These reports provide basic data regarding premium income and claim payments during the month.

The State received a Utilization Report for the 1981-1982 plan year from BC on September 22, 1982. This report included an analysis of claim payments by:

- . Diagnosis,
- . Age of patient,
- . Nature of Service, and
- . Place of Treatment,

for all payments during the plan year.

Usefulness of Data

The monthly data provides information to the D of A and consultant for monitoring claim payment volume both as to numbers of claims and total amounts paid. Additional information regarding the nature of the charges and the incurred claim delay is useful in evaluating claim-to-premium ratios, trends in plan utilization and future financial needs.

The annual data includes more detailed evaluations of claim information, permitting more in depth analysis of claims for cost control purposes.

The reports we reviewed did not contain the following information we believe to be useful to plan administrators and consultants:

- . Evaluation and comparison of frequency of hospital admission and length of stay by diagnosis and age/sex groups,
- . Average cost per day of hospital treatment by diagnosis and age/sex groups,

- . Savings to the plan from the Coordination of Benefits provision, and
- . Savings to the plan from the Reasonable and Customary provision.

The availability of this information, in addition to that currently provided, would permit D of A, BC and the consultant to compare claim statistics to other Montana, Regional, and National data and monitor the effectiveness of cost control activities.

Timeliness of Data

The monthly data is generally available by the 15th day following the close of the month. The annual data was received less than two months following the close of the Plan Year. Based on our experience with other health care and dental care plans, BC is providing the data on a timely basis.

Accuracy of Data

We reviewed the accuracy of data presented in the monthly reports. Inaccuracies were noted in the June reports. The errors in the June report were traced to a coding error resulting in claim charges to the State's Plan that were incurred by participants in other employers' plans. This error was discussed with BC and we have been advised that the coding error has been corrected and the charges have been removed from the State's Plan.

USE OF DATE AND REQUESTED DATE

During our review, we interviewed Mr. Michael Arnold at EBB. Mr. Arnold's responsibilities include the development of cost containment programs for the Plan and the analysis of management reports provided to BC. Mr. Arnold reported that he is currently reviewing available data and evaluating his need for further management report information.

We also discussed the availability of further information with Mrs. Janet Haffner, Vice President at BC. She advised us that they are prepared to respond to the State's management report needs.

VI - CONCLUSIONS AND RECOMMENDATIONS:
CLAIM PAYMENT PROCESS

Our conclusions and recommendations, based on our audit of the claim payment accuracy and turnaround time for health care and dental care claims processed during the 1981-1982 plan year, are presented below.

CONCLUSIONS:
CLAIM PAYMENTS

We conclude the following regarding claim payment accuracy.

Health Care Claims

The health care claim payment accuracy observed during our audit was very good. We conclude that BC personnel and the computerized claim payment system processed health care claims during the 1981-1982 plan year with a very high degree of accuracy.

Dental Care Claims

As part of our audit and review services for the 1980-1981 plan year, we reviewed the BC dental claim system. We identified and made recommendations regarding potential problems in the dental claim system. Our report included recommendations regarding crowns and flouride treatments. Based on our experience, audit results for the first year of a dental care plan are not favorable. Errors tend to occur in contract interpretation and computer programming of plan benefits. Once identified and corrected, these errors are reduced or eliminated and the audit results tend to improve. The 1981-1982 plan year was the first year BC paid dental claims under the State's plan. Prior to that year dental claims were paid by Aetna.

BC personnel need further training regarding the State's dental benefits. The computerized claim system could be modified to reduce or eliminate payment errors for extractions, crowns, and flouride treatments for adults.

If the recommendations regarding dental care claims, listed below under RECOMMENDATIONS, involving extractions, crowns, and flouride had been effective for the 1981-1982 plan year; the frequency of error may have been reduced to 3.5 percent of our sample and the net underpayment may have been reduced to about .4 percent of our sample.

Turnaround Time

Turnaround time during the first six months of the plan year was very slow. Difficulties with the computer processing system caused delays beyond normally acceptable turnaround time.

We further conclude that turnaround time during the second six months of the plan year improved to a generally acceptable level.

RECOMMENDATIONS:
CLAIM PAYMENTS

Our recommendations regarding the BC claim payment function are presented below.

Health Care Claims

The payment accuracy for health care claims is very good, as stated above. We recommend BC continue its processor training program to improve the identification of accident claims and noncovered items.

Dental Care Claims

We recommend the following to improve claim payment accuracy under the dental care plan:

- . Modify the computer program to limit the payment for tooth extractions to 50 percent of a reasonable charge.
- . Modify the computer program to limit crowns to a payment equal to the payment for a four-sided amalgam restoration.
- . Instruct claim processors to check the age of patients for whom fluoride treatments are received.
- . Improve processor training regarding claim form review and covered services.

Payment accuracy regarding these recommendations should be tested during the current plan year to determine the degree of improvement in payment accuracy prior to the end of the 1982-1983 plan year.

Claim Turnaround Time

We recommend the following regarding turnaround time:

- . BC and D of A should develop a participant and provider education program to improve the quality and quantity of information received on the initial claim submission, and
- . D of A should develop a follow-up procedure designed to record all complaints received regarding slow turnaround time. Each such complaint should be discussed with BC and the explanation of reasons recorded and communicated to the patient or employee.

VII - CONCLUSIONS AND RECOMMENDATIONS:
STATE ADMINISTRATION

Our conclusions and recommendations, based on our review and audit services regarding the State's administration of the benefit program are presented below.

CONCLUSIONS

We conclude the following regarding benefit program administration:

Prior Year's
Recommendations

D of A has taken action on most of the recommendations made in our January, 1982 report. Based on our review and audit, the action taken has improved the administration of the benefit programs at both the agency and D of A level. Improvements in the Payroll Clerk instructions and training plus revisions in EBB work procedures appear to have been effective in reducing administrative errors and the time required to prepare premium reports.

Review and Audit of
Eligibility and Premium

Based on our review and audit of the eligibility verification and premium collection process, improvement has been made in the proper enrollment of eligible employees and the collection of appropriate premiums through payroll deduction. Our audit results of eligibility and premium discrepancies indicate that many errors during the 1981-1982 plan year were produced because payroll deductions did not match the coverage requested on the enrollment or status change forms.

Payroll Clerks may not be reviewing pre-payroll listings on a monthly basis to identify and process newly eligible employees.

RECOMMENDATIONS

Our recommendations regarding the eligibility verification and premium collection process are presented below.

Eligibility Verification

Our audit results indicate that Payroll Clerks do not consistently obtain enrollment forms or waiver forms from eligible employees on a timely basis.

EBB personnel should periodically review the status of employees not enrolled for benefits to verify that those eligible for benefits but not participating have completed a waiver card declining coverage.

A procedure should be developed to notify BC on a timely basis of employees who terminate their benefit coverage.

Premium Collection

Discrepancies between enrollment card coverage and payroll deductions have resulted in:

- . Payroll deductions exceeding authorized amounts based on enrollment card coverage requests, and
- . Payroll deductions of less than the needed amount based on enrollment card coverage requests.

Incorrect deductions require additional transactions to correct the error and refund checks may need to be requested to refund excess deductions. Deductions of less than the needed amounts have caused delays in claim payments by BC.

The enrollment (and coverage change) procedures and payroll deduction notice procedures should be revised as follows:

- . EBB should design a single, uniform coverage form for life, health and dental coverages to be used to:
 - Enroll employees when first eligible,
 - Change employee coverage when requested,
 - Decline coverage if so desired, and
 - Report payroll deduction requests.
- . Payroll Clerks should complete the enrollment (or coverage change) procedures and appropriate payroll deduction requests for an employee as one process.
- . Completed forms should then be sent to EBB for review and determination that one time and regular deductions match the coverage requested.
- . EBB should then send a copy to support payroll deduction requests to Central Payroll and a copy to BC for coverage purposes.

VIII - CONCLUSIONS AND RECOMMENDATIONS:
MANAGEMENT REPORTS

Our conclusions and recommendations regarding management reports provided by BC are presented below.

CONCLUSIONS

Based on our review of the management reports provided by BC, we conclude the following:

- . The reports prepared by BC are useful to the State. However, additional information would be of value to the State, BC and the consultant.
- . Reports appear to be presented on a timely basis as compared to the timing of similar reports received by other employers with which we are familiar.
- . Monthly reports contained erroneous information resulting from a coding error which was subsequently identified and corrected by BC. We did not note additional errors during our review.

RECOMMENDATIONS

Based on our evaluation of the current management reports, discussions with EBB employees, and experience with similar plans; we make the following recommendations:

- . The State should develop a list of management report information needed and a description of the format for this information and present it to BC.
- . BC should develop these additional reports and provide the information to the State on a timely basis.
- . Additional reports should include information regarding:
 - Frequency of hospital admission by diagnosis and age/sex groups,
 - Length of hospital stay by diagnosis and age/sex groups,
 - Average claim payment and cost per hospital day by diagnosis and age/sex groups, and
 - Savings resulting from administration of coordination of Benefits and Reasonable and Customary provisions.

This information can then be compared to similar information for other employers and used to monitor the results of cost containment efforts. Our recommendations regarding additional information should be reviewed by Mr. Arnold at EBB to determine if the information matches his need and further reviewed by the State's consultant who is, in part, responsible for providing advice on this subject.

DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

TED SCHWINDEN GOVERNOR

ROOM 130 MITCHELL BUILDING

STATE OF MONTANA

(406) 449-3871

HELENA, MONTANA 59520

November 22, 1982

Raymond O. Wolcott, Jr.
Peat, Marwick, Mitchell and Company
2000 Commerce Tower
P. O. Box 13127
Kansas City, Missouri 64199

Dear Mr. Wolcott:

I have received and reviewed the draft report of your audit of the State of Montana Employee Group Benefit Plans. Listed below are the Department of Administration's comments on the draft report.

III. Results: Claim PaymentTurnaround Time

In this analysis, acceptable turnaround time was based upon a period of 14 days. This 14 day period was then extended to 18 days for dental claims and 20 days for medical claims to compensate for an "average" delay in the payment cycle.

In analyzing turnaround time during the last six months of the contract, the report identified 71 out of 204 claims that were paid in excess of the 18 or 20 day acceptable period. The report then excluded 25 of the 71 claims because they appropriately required a longer time to process. The report also excluded 27 of the 71 claims because they were processed within 14 days, but the payment cycle produced a delay beyond the 18 or 20 day acceptable period. The report then goes on to state that, "185 or 91 percent were processed within an appropriate turnaround time or included proper documentation of a delay which was not a fault of the claims adjudication system."

The problem with this analysis is that for each of the 27 claims that were processed within 14 days but paid in excess of the 18 or 20 day period, there are probably more that were processed in excess of the 14 day period but were paid within the 18 or 20 day period. These claims were recorded as being processed within an appropriate turnaround time when they in fact were not.

Raymond O. Wolcott, Jr.

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As a result, during the last six months of the contract, probably less than 77 percent of the claims were processed within an appropriate turnaround time or included proper documentation of a delay which was not a fault of the claims adjudication system.

IV. Results: State Administration Prior Year's Recommendations

Termination Information

Employees are advised of their continuation and conversion benefits in the Employee Benefit Plan Handbook. We also encourage each agency to provide conversion information to their employees. Blue Cross of Montana also provides conversion information for the health plan to each employee that terminates. We feel that the information provided is sufficient.

Leave of Absence

Payroll clerks presently review the pre-payroll listing and contact employees that are not in a pay status to provide self-pay information. We will modify this procedure and ask payroll clerks to send a standardized reminder request to employees that are not in a pay status. This reminder will include the amount of the self-pay, the date due and a notice that failure to comply will result in termination of coverage. Retroactive self-pay requests will not be allowed.

Employee Benefits Bureau Administration Manual

A manual describing the administrative activities in the Employee Benefits Bureau was developed shortly after the last audit. In addition, an employee from the compensation function of the Employee Benefits Bureau is being cross trained in the administrative activities of the health, dental and life insurance function. This will provide protection in case of employee turnover or promotion.

VI. Conclusions and Recommendations: Claim Payment Process

Claim Turnaround Time

The Employee Benefits Bureau will meet with Blue Cross of Montana in an attempt to identify the type and magnitude of information missing from initial claim submissions. If a cost effective provider and/or participant education program can be developed, the Employee Benefits Bureau will work with Blue Cross of Montana to implement this program.

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The Employee Benefits Bureau refers all inquiries and complaints, including slow claim payment, to the Blue Cross of Montana Customer Service Department. The Employee Benefits Bureau does not generally become involved in complaint resolution except on an appeal basis if it cannot be resolved between Blue Cross of Montana and the participant. We do record these appeals and communicate with Blue Cross of Montana and the participant concerning the final disposition.

VII. Conclusions and Recommendations: State Administration

Eligibility Verification

Each agency will be reminded to review on a monthly basis those employees not enrolled for benefits to verify that employees eligible for benefits but not participating have completed a waiver card declining coverage. In addition, the Employee Benefits Bureau will conduct the same review on a six-month basis.

A procedure has been developed and implemented to notify Blue Cross of Montana of employees that terminate their benefit coverage. The edit list provided monthly to each agency now identifies terminated employees. Each payroll clerk has been asked to make a termination list from this edit list. The termination list will include the employee's name, social security number, and date coverage should end. These lists are sent to Subscriber Accounting at Blue Cross of Montana.

Premium Collection

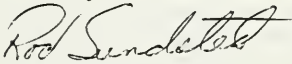
The recommendation to develop an omnibus form to be used for enrollment, change of status, and waiver of coverage for the health, dental and life insurance plan will be adopted with two exceptions. First, the omnibus form will not be implemented at the present time. Because changing forms is likely to cause confusion among the 150 payroll personnel responsible for filling them out, we will wait and time the change with a formal training session or some other event which would cause a change in the present forms. Second, payroll deductions will continue to be reported on a separate form. The present payroll deduction form is also used to designate deductions for union fees, deferred compensation and many other deductions. Putting health, dental and life deduction information on the omnibus form would require that two separate deduction forms be sent to Central Payroll for the same employee.

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Having enrollment, change of status and payroll deduction forms sent to the Employee Benefits Bureau for review of coverage and deduction figures would catch most deduction errors made by agency payroll clerks. However, at the present time I am not sure the Employee Benefits Bureau has the resources available to conduct such a review. We will monitor the number of enrollment and change of status forms that are processed to determine the time required to conduct such a review. If possible, this recommendation will be adopted.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rod Sundsted".

Rod Sundsted, Chief
Labor Relations and Employee
Benefits Bureau

RS/pb

Blue Cross.
of Montana



P. O. Box 5004
3360 10 Avenue South
Great Falls, Montana 59403
Phone: 761-7310

November 10, 1982

Mr. Ray Wolcott, Jr.
Peat, Marwick, Mitchell & Company
P. O. Box 13127
Kansas City, Missouri 64199

Dear Mr. Wolcott:

The following represents the response by Blue Cross of Montana to the draft report of the audit performed on the State of Montana employee health and dental benefit plan.

Blue Cross of Montana is in agreement with the findings and supports the recommendations made by the auditors.

The area found to have the highest degree of errors and most easily correctible is in the dental portion of the contract. A recommendation was made to limit payment for tooth extractions to 50% of reasonable charges. This correction was made in our system on August 6, 1982, just prior to the time of the audit. It was recommended that this system be changed to insure that we do not pay for fluoride treatments on patients over 19 years of age. We appreciate you pointing out this weakness in our system. This recommendation was implemented on all of our dental business during the time you were in the Plan. The third area a recommendation was made is where we were paying crowns as crowns and not as a four surface filling. This recommendation has not yet been automated, but we are confident it has been corrected through an educational process of our dental processors.

As pointed out in your exit conference, with the correction of these three error conditions, our payment accuracy would be at an acceptable level.

We thank you for the opportunity to comment on this audit report and appreciate the recommendations made to strengthen our system. We will continue to work with the Department of Administration to solve our mutual problems and satisfy the needs of both organizations.

Sincerely,

Carl J. Tanoerg
Vice President, Provider Service
Blue Cross of Montana

CJT:wph

